Researching ‘Wicked’ Issues – ‘Messy’ World of COR

Jennifer Jackson
Community Operational Research Unit
University of Lincoln

UNIVERSITY OF LINCOLN

What is Community OR?

- Community OR – no ‘precise, neat and tidy definition’ White and Taket (1994)
- Providing ‘spaces’ for organisations to think through issues and action?
- Structuring contestable forms of knowledge to aid policy makers and practitioners with their ‘wicked’ problems and potential solutions of how to act?
- ‘The goal of any research is to provide information that is not only true, but which is also of relevance of issues to human concern’ (Hammersley 1992)

Health inequalities – ‘wicked’ issue?’

- Health inequalities –wide literature but how to define the ‘problem’ and potential ‘solutions’ from Black Report (1980) to Marmot Review (2010)
- Structural causes – socio-economic argument
- Behavioural/individual causes – lifestyle ‘choices’
- Access/Services – service appropriateness/delivery
- Central debate - inter-action between the theories - structural and behavioural

Lincolnshire Probation's Healthy Living Centre Model

- CORU 5 year engaged 'evaluation' project 20003-8 on specific 'vertical' health model within Lincolnshire Probation
- Healthy Living Centres - 'Vertical' model of health delivery – 'platforms of innovation' - targeted interventions for those most affected by health inequality
- Lincolnshire probation most 'unique' of 351 designated HLCs – nurses based in probation providing individual and personalised health assessments and consultations to offenders
- Advocacy, signposting and onward referral – support for offenders and offender 'managers'

Nature of Inequality?

- Social Exclusion Unit (2002) –approximately half of all prisoners had no GP before custody – circle of social exclusion, poor health and offending
- Sattar (2001) – offenders in the community had a higher mortality rate than those in prison and the general population

  Death rate: 449.5 per 100,000 offenders in the community
  258.8 per 100,000 general population
  189.8 per 100,000 prisoners
- 70% of prisoners entered prison with a drugs misuse problem – but 80% never had any contact with drug treatment services (SEU 2002)
- 13.8% not eating a meal every day (Lincolnshire Probation HLC screening)
- 75% smoking (Lincolnshire Probation HLC screening)
- 65% not registered with a dentist (Lincolnshire Probation HLC screening)

Offender Health – Identifying a Gap in Research

- Health inequalities – concentration on ‘observable and measurable‘ – descriptions of health inequality – rather than ‘how to act’
- Very little specific to the health needs of offenders on community sentences
- Concentration on health issues already identified as pertinent to offenders ie substance and alcohol misuse
- Few studies including offender/hard to reach views on health and health services – research ‘on’ target disadvantaged groups than with them

Lincolnshire Probation’s HLC exceptional opportunity to research:

Alternative/’vertical’ service models and health structures

Understanding of health inequality from the ‘micro’ level – ‘coal face’ of health inequality

The enablers and barriers in pathways to health services and change

Research tools / Primary data sources

- Snapshot survey for original bid (2001)
- Engaged, participatory research (2003-08)
- Stakeholder Interviews (2004 - 2006)
  - views of offenders [27] HLC team [8] and Case Managers [12] on health and the HLC
  - plus focus groups with offenders [9]
- Offender Health survey (2007) – 100 offenders
- Food and Mood Project (2007) – at approved premises
- Health Inequalities Impact Assessment
- Project data collection

Challenges of the Research Process – Reaching the 'hard-to-reach'

Expected To Attend	Did Attend	Did Not Attend	Interviewed	Unwilling To Be Interviewed
5	1	4	1	0
3	2	1	1	1
3	0	3	0	0
2	1	1	1	1
5	0	5	0	0
3	1	2	1	0
3	1	2	0	0
3	1	2	0	1
3	1	2	0	1
3	1	2	0	1
3	1	2	1	0
36	**10**	**26**	**5**	**5**

Engaged Research

- Not just gathering snapshot data and views in a vacuum, but fluid and continuous debate between Researcher and 'researched' about emerging research issues

- Contested nature of 'evidence'/knowledge – culture of organisational targets v understanding processes and structures 'government in a hurry'/short termism of policy

- Research partnerships one of constant negotiation

  '…research roles are constantly negotiated and renegotiated with different informants throughout a research project' (Burgess 1991)

‘Voices of offenders’
Added Value of HLC - Time

- ‘…The nurse has got time to listen to me…with the GP you spend more time waiting to see him, than the time to actually see him’, you are ‘in and out in 2 minutes’. Then all they do is say ‘yeh, yeh blah blah…give you a prescription and a piece of paper…they don’t really sort you out…’

- ‘You don’t have to get past the receptionist and then have 5 minutes with the GP to just pick up some medication, with all your issues still to resolve’

- ‘…If you go into the GPs all you get is a few minutes of time and then they want you out, where is the next patient? I spent 3 and a half hours talking to the nurse and you couldn’t do that with a GP’

- ‘It is much better seeing the nurse than the GP as they have much more time .. otherwise it’s a case of ‘what’s wrong with you .. now it’s someone else’s turn. You know that there is not Mrs Jones in the waiting room and you have to get on’…

Voices of offenders: Added Value of HLC – *rapport / trust / personalising the Service*

- ‘I could go and talk to the nurse about anything that was bothering me – even if I had a ‘wart on my willy’. I would have no embarrassment or difficulty about talking to the nurse about it. It really helps to have the time to talk through your problems. In fact when I am talking to the nurse I forget that I am talking to a trained nurse, its just as if I am talking to someone I have known for a very long time, so I can talk about anything I want.

- ‘I can speak to the nurse all the time and ask questions, which eases you … this is not something that I would do at a GP.’

- ‘You need counselling and someone to talk to about things, as much as you need medication.’

Voices of Offenders: Added Value – *Personalising Health Messages / Motivation for Change*

- **‘**They give you the choices, the advice, the telephone numbers’.
- ‘They get me on the scales and take my blood pressure and keep nagging me about my smoking without telling me what to do’.
- ‘They (nurses) don’t bombard you – otherwise you would probably be more defensive and go against them’.
- ‘I found out things that I wasn’t aware of. I put the leaflets about healthy eating in the drawer – but have now got them out and am reading them and acting on the advice’.

Health and the Criminal Justice System – Role of HLC

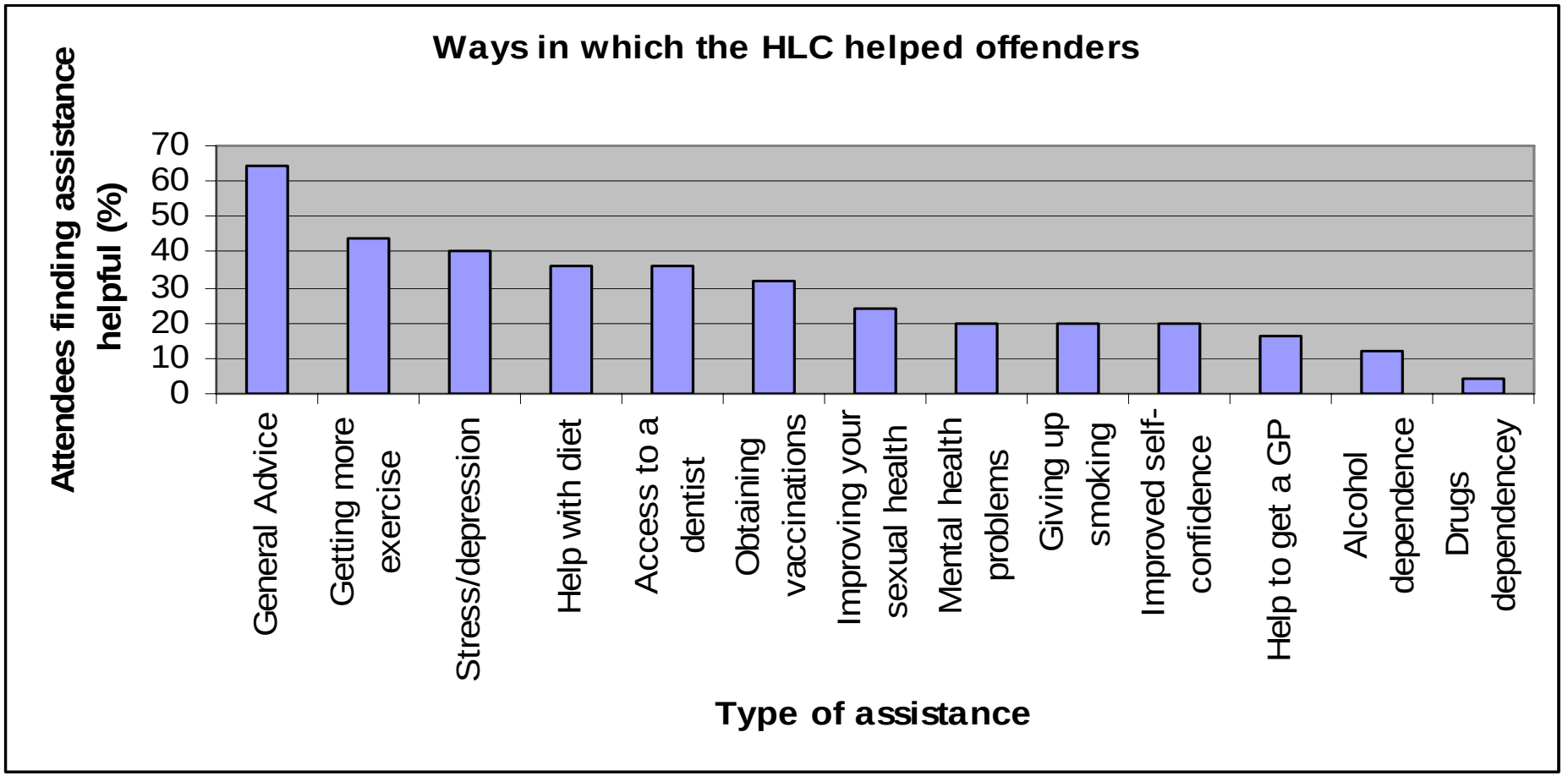
Identification and prioritising of need – placing of systems boundaries:

> Since I have been part of the Criminal Justice System I have got access to far more help and medical treatments than before … it almost makes you feel that you need to be part of probation again to get the treatment that you need.

Offender Voices:

- 'Had just come out of prison so it was a nice friendly service as I wasn't ready at that point to meet people and go to a doctor's surgery and wait there'.
- 'Drs are very much about authority and after 7 years in prison you become institutionalised and so the nurses approach is very good'.
- 'In prison they isolate issues too much like drugs and alcohol – they put you in boxes – don't look at the problems of addiction as a whole.'

Holistic Approach – Types of support attendees found helpful



Behind the Images?

- Often people assumed by health educators to constitute a community (for example intravenous drug users) turns out to be a heterogeneous group, rather than a peer group characterised by a common identity – which would bind information together in the task of renegotiating behavioural norms and practices. Social interaction and solidarity do not automatically flow from the fact of addiction to a common substance, as many programme organisers have so optimistically assumed…Much more works needs to be done in developing understandings and actional models of what constitute the ‘communities’ whose existence is presupposed by so many educational interventions

  Campbell et al (1999)

(self) Perceptions of behaviour – Two ‘healthy’ people

- RESPONDENT ‘A’

- Never smoked
- Not stressed
- No illegal drugs
- Doesn’t drink

- RESPONDENT ‘B’

- Smokes daily
- Stressed through:
  - unemployment
  - Housing
  - drugs
- Takes: crack cocaine, cannabis, methadone and heroin
- Drinks 9 units daily

Pathways to Change

- ‘ I got to my 38th birthday and thought where’s my life gone? It really upsets me to think how much my life has been screwed up…’
- ‘Only now that I realise how important health is…I got into soft drugs at 18, then heroin had a really ‘bad effect’ on my life…I got into trouble…At 23 I decided I had to sort my life out…I am now seriously getting off the drugs and getting my life back…’
- ‘As a lad I couldn’t care less about health…my life was chaotic. I didn’t have a family…my circle of friends were all a bad influence, I lived on a bad council estate and just got into drugs and everything that was bad. I have just started to realise that this is not a life…
- ‘I am starting to feel good about something and excited and capable and that is a new feeling. I never used to make plans … I used to live day by day. I have now structured my life and feel that there is something to live for …’

Barriers to Change – 'Trade offs' – Health 'Values'

- Health not unitary concept: Blaxter (1990). There are also trade-offs:
- 'If I gave up smoking I would get bored and start taking drugs instead.'
- Other assumptions about health needs and profiles challenged – desire to prolong life:
- 'I don't care about being healthy .. I want to die and don't know why people want to keep me alive'
- 'I am not really worried about the length of my life…I live for the moment.

Barriers to Change – routine/coping

- ‘Cost’ of change/threatened by change:

  Routine, control and coping strategies – rationality and ‘crutches’ for everyday life – pleasure now against uncertain long term health consequences in difficult lives
- ‘Smoking is my safety pillow’
- ‘Mostly you take drugs and smoke to deal with the stresses of life’
- ‘I want to give up smoking – but it’s a habit to turn to – you use it as a crutch, it’s an addiction. The alcohol is also a crutch.’

Barriers to Change – Challenge/Questioning of Health Messages

- Population/Epidemiological paradox – 'lay' knowledge individual experience v scientific/official population data

- 'The Government warnings on smoking are like water off a duck's back. You can have someone who lives to 92 who has been smoking heavily all his life and still has a fine pair of lungs. That's one statistic amongst the other statistics.'

- 'Although they say that 'smoking kills', people who don't smoke also get cancer – so it doesn't really affect me. You have to live your life.'

Barriers to Change: risk and resistance to the Health Message

- ‘You might get a flash when you see something like ‘smoking kills’ … but then later you pick up a fag.’
- ‘It’s all do this and do that and you think sod ‘em.’
- ‘It’s the risk that you are chasing.’
- ‘I’ve shared needles and put myself at risk, you think about the risk for one second and then the next second you think about the fix.’
- ‘…when you’re brown bread, you’re brown bread – that’s all there is to it and when your time’s up, your time’s up … Life is difficult, I could die tomorrow in an accident, so why worry about something like smoking.’

Final Reflections: Health Equity/ Societal 'good'?

- Moral 'good' of the health inequality debate challenged – assumptions made about what disadvantaged/vulnerable groups 'need' ie that they lack control over their lives for more healthier lifestyles (Marmot 2012) 'Right'/choice to be 'unhealthy' as much healthy
- Complex nature of 'wicked' societal issues both in understanding their causes and potential solutions – paradoxes and contradictions at the micro level – should we intervene and how?
- 'Lessons' learnt from vertical intervention for mainstream services – need for more permeable services for vulnerable groups and what it informs us about the gaps in mainstream health delivery?

Contact Details

Jennifer Jackson
Research Fellow
Community Operational Research Unit
University of Lincoln

jjackson@lincoln.ac.uk
01522 835598